STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004972	A. BUILDING: _____ B. WING _____	01/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS	8111 S EMERSON AVE INDIANAPOLIS, IN 46237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The visit was for investigation of a State complaint. Complaint Number: IN 00173595 Substantiated; no deficiencies related to allegations are cited Date: 1-19/20-16 Facility Number: 004972 Franciscan St Francis Health-Indianapolis is in compliance with 410 IAC 15-1.5-5, Medical Staff and 410 IAC 15-1.6-7, Respiratory care services, Indiana Hospital Licensure Rules. QA: cjl 03/08/16	S 000		